**Fibromyalgia and Chronic Fatigue Syndrome**

It is estimated that fibromyalgia affects 2% of the general population in the USA with a significant preponderance in women. It is one of the pain syndromes which many researchers and clinicians now believe forms part of a larger continuum of so-called "central sensitivity syndromes".

In some treatment centres in the USA it has been observed that the many chronic fatigue syndrome (CFS) sufferers experience fibromyalgia and similarly it has been reported that up to 70% of patients with fibromyalgia meet the criteria for CFS. As such the broader principles of treating fibromyalgia and chronic fatigue syndrome significantly overlap.

Fibromyalgia and CFS are exclusively defined by a set of symptoms reported by the patient and as there are no regular physical examination abnormalities and no diagnostic laboratory tests the processes of diagnosis and treatment are somewhat integrated. So while confirmation of the diagnosis remains paramount the clinician should simultaneously start to prioritise and devise a symptoms management programme.

It is not possible to resolve these disorders in one single clinical consultation and as such some experts in the field recommend following the CFS triangle made up of sleep, pain and fatigue. It may therefore be prudent to treat the sleep disorder first followed by the fibromyalgic pain and then the fatigue.

Diagnosis of fibromyalgia and CFS remains challenging although it must be borne in mind that the presence of any of the following conditions would exclude such a diagnosis:

- Treated or untreated medical conditions that would otherwise explain the symptoms
- Major depressive disorder with melancholic or psychotic features
- Bipolar disorder
- Schizophrenia or delusional disorders
- Dementia or other organic brain disorders
- Anorexia nervosa or bulimia nervosa
- Alcohol or substance abuse within the last 2 years
- Severe obesity (BMI ≥ 45)

The diagnostic process must include continuous periodic reassessment as the diagnosis may become clearer with time although it must be borne in mind that making the diagnosis is often very helpful for the patient as the she or he is reassured that their illness is real and not imagined. Fibromyalgia and CFS may occur with other adequately treated co-morbidities such as irritable bowel syndrome and interstitial cystitis.

With regard to treatment there is insufficient evidence to support most specific therapies for fibromyalgia and CFS. Cognitive behavioural therapy and graded exercise therapy and water therapy have been shown to be helpful although they are not curative.

Sleep therapy includes practising good sleep hygiene. A first line in pharmacotherapy might include OTC medications e.g. melatonin or diphenhydramine. A second choice would be a tricyclic antidepressant (TCA) e.g. amitriptyline. The next step may be to use the non-
benzodiazepine hypnotic agents such as the so-called “Z-drugs” i.e. zopiclone, zolpidem and zaleplon although these medications can be habit-forming.

Non-pharmacologic treatment of fibromyalgic pain includes modest physical activity, cold and hot packs, topical liniments, a TENS (Transcutaneous Electrical Nerve Stimulation) unit and EMS (Electrical Muscle Stimulation). Pharmacologic treatment such as COX-2 inhibitors may be useful for joint discomfort and generalised myalgias but are not effective against fibromyalgic pain. Tricyclic antidepressants such as amitriptyline, nortriptyline and imipramine may prove a more effective next step.

The FDA has now approved 3 medications for the treatment of fibromyalgia and include an anti-epileptic drug (an alpha 2-delta ligand) called pregabalin (lyrica) and 2 SNRIs i.e. duloxetine and milnacipran. The use of opioids is not encouraged although some studies have shown opiates/opioids to be affective against fibromyalgic pain. It is advised to involve a pain specialist should opioids such as Tramadol (Tramacet) be used in treating fibromyalgic pain.

Furthermore evidence for the use of the following medications in the treatment of fibromyalgia has been demonstrated:

- **Selective Serotonin-reuptake Inhibitors**
  - Fluoxetine (Prozac)
  - Paroxetine (Aropax)
  - Citalopram (Cipramil)

- **Serotonin- and Norepinephrine-reuptake Inhibitors**
  - Venlafaxine (Effexor)

- **Alpha2-delta Ligands**
  - Gabapentin (Neurontin)

- **Miscellaneous**
  - Odanosteron (Zofran)

- **Atypical Antipsychotics**
  - Olanzapine (Zyprexa)
  - Quetiapine (Seroqual)

- **Dopamine-receptor Agonists**
  - Pramipexole (Pexola)

The use of the above medications is recommended for the treatment of fibromyalgic pain according to the following stepwise treatment protocol:

**Step 1**
- Confirm the diagnosis
  - Making the diagnosis is often very helpful for the patient and there is evidence to suggest that it may help reduce morbidity in the long-term
  - The benign nature of the disorder must also be emphasised as this will further facilitate the patient's ability to adapt and cope with their illness
- Identify important symptom domains and their severity (pain, sleep disturbance, fatigue) and level of function
• Evaluate co-morbid medical and psychiatric disorders (sleep apnoea, osteoarthritis, depressive or anxiety disorders)
• Assess psychological stressors, level of fitness, barriers to treatment
• Provide education about fibromyalgia and CFS
• Review treatment options

Step 2
• Recommend treatment based on the results of the individual's evaluation
• For patients with moderate to severe pain offer a trial of medication as a first line approach
• Start with a trial of selective serotonin and norepinephrine reuptake inhibitor (not recommended as monotherapy for patients with fibromyalgia and co-morbid bipolar disorder)
• In patients with prominent sleep disturbance or anxiety offer a trial of alpha 2-delta ligand
• If there is only a partial response to mono therapy with SNRI or alpha 2-delta ligand then commence with a trial of a combination of these agents
• If there is no response to the above approach then consider other medications i.e. SSRI, TCA, or a combination of SSRI with low dose TCA, or a combination of SSRI and an alpha 2-delta ligand
• Avoid drugs with a high likelihood of abuse or dependence
• Treat co-morbid conditions (Non steroidal anti inflammatory drugs for osteoarthritis, continuous positive airway pressure for sleep apnoea)

Step 3
• Adjunctive CBT for patients with prominent psychosocial stressors.
• Exercise prescribed according to fitness level (30-60 minutes of low moderate intensity aerobic exercise at least 2-3 times a week)

Prognosis
By definition all patients with fibromyalgia and CFS are impaired although this does not necessarily equal disability. The US Department of Health and Human Services notes that many patients may be able to adapt by consulting with their employers and rehabilitation specialists.

Long term outcomes of fibromyalgia and CFS cannot be predicted in individual patients. In patients with CFS characterised by acute onset illness (often after an infection) many appear to improve after 2 years whereas those with fibromyalgia and gradual onset CFS may experience a prolonged illness characterised by remissions and exacerbations. Symptom improvement is still possible in people who have been ill for many years.

Claims Assessment Considerations
Assessing disability claims for fibromyalgia and chronic fatigue syndrome can be challenging given the subjective nature of the complaints. These claims tend to be of a lengthy duration and once admitted, can be very difficult to manage. As there are no objective tests that conclusively confirm the diagnosis, we recommend that the following are considered in the assessment process.

New claims should be investigated thoroughly before being admitted. The claimant should have consulted a specialist rheumatologist or physician for diagnosis and treatment prior to submitting a disability claim. If the claimant has been diagnosed by a general practitioner, an independent assessment by a specialist should be obtained before admitting the claim. Other conditions that would exclude the diagnosis of CFS should have been investigated and ruled out by the time a claim is assessed. (See the medical guidelines)
Obtain a detailed history regarding all treatment options that have been tried and the outcome of these. You may want to make use of an activity diary to determine how the claimant spends their time or obtain collateral information from other sources, to verify their activity levels.

An occupational therapy evaluation should focus on their level of functioning, motivation to return to work and their job tasks and work environment.

Once the claim has been accepted, income benefit claims should be managed actively with a view to returning the claimant to some form of occupation.

They should be managed by a specialist and other health professionals consulted as needed. An active case manager may need to be appointed to ensure a smooth transition back into the workplace.

Lifestyle changes and alternative treatments may be helpful in reducing the symptoms and assisting the claimant to cope. For example, consider physiotherapy, massage, mild aerobic exercise, stress management techniques and other supportive therapies.

PGAP programmes and Cognitive Behavioural Therapy are therapeutic tools available which may be beneficial in assisting the claimant to cope with their condition.

References